This is a **Sample** version of the

Apathy Evaluation Scale (AES)

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- AES Overview information
- AES Scoring/ Administration instructions
- AES Complete Quesionnaire/ Assessment
- AES Clinical Validity

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Reliability and Validity of the Apathy Evaluation Scale

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Abstract. This article presents evidence for the reliability and construct validity of the Apathy Evaluation Scale (AES). Conceptually, apathy is defined as lack of motivation not attributable to diminished level of consciousness, cognitive impairment, or emotional distress. Operationally, the AES treats apathy as a psychological dimension defined by simultaneous deficits in the overt behavioral, cognitive, and emotional concomitants of goal-directed behavior. Three versions of the AES (clinician, informant, and self-rated) were evaluted for 123 subjects, ages 53-85, meeting research criteria for right or left hemisphere stroke, probable Alzheimer's disease, major depression, or well elderly control. Multiple forms of reliability (internal consistency, test-retest, and interrater) were satisfactory. Several types of validity evidence are presented for each version of the scale, including the following: ability of the AES to discriminate between groups according to mean levels of apathy, discriminability of apathy ratings from standard measures of depression and anxiety, convergent validity between the three versions of the scale, and predictive validity measures derived from observing subjects' play with novelty toys and videogames. Guidelines for the administration of the AES are presented, along with suggestions for potential applications of the scale to clinical and research questions.

Key Words. Apathy, depression, dementia, geriatrics, motivation, negative symptoms, organic personality disorder, poststroke affective disorders, stroke.

Apathy has been described in a variety of clinical disorders and is an important psychological response to many major life stressors. For clinical purposes, apathy means lack of motivation that is not attributable to diminished level of consciousness, cognitive impairment, or emotional distress (Marin, 1990). The behavioral changes associated with right hemisphere stroke (Gainotti, 1972; Robinson et al., 1984), frontal lobe injury (Hecaen and Albert, 1975; Stuss and Benson, 1975), and negative symptoms in schizophrenia (Crow, 1980; Andreasen, 1982) are examples of such apathetic syndromes. Apathy also occurs in association with a variety of other clinical problems and may complicate both assessment and treatment (Marin, 1990).

No instrument has been developed specifically to measure apathy, despite its

ubiquity. The Apathy Evaluation Scale (AES) was developed to quantify and characterize apathy in adult patients. It treats apathy as a psychological dimension that may be evaluated in patients whose apathy characterizes their overall clinical state, and those in whom it is a symptom of some other syndrome, such as delirium, dementia, or depression. This report describes the development, reliability, and validity of the AES. The AES was developed for multiple rater sources: clinician, informant, and self-rated versions (AES-C, AES-I, and AES-S, respectively). Using multiple sources of information permitted evaluation of potentially complementary sources of information. Apathy is often associated with impaired insight—for example, because of its association with frontal lobe injury (Hecaen and Albert, 1975; Stuss and Benson, 1975) or dementing disease (Sjögren et al., 1952; Sourander and Sjögren, 1970; Reisberg, 1983). For this reason, we developed AES versions for a clinician and informant (family member, friend, or caregiver). The informant version complements the clinician version since it is based on direct observation of subjects' behavior in a home environment. By contrast, the clinician version is based on clinical observations and subjects' self-reports during an interview. Despite the obstacles posed by cognitive impairment, insight, or denial of illness, we also tested a self-rated version since it was expected that self-ratings might have at least some validity.

Internal consistency, test-retest, and, for the AES-C, interrater reliability are reported. Regarding validity, three questions are addressed.

1. Can apathy be discriminated from depression? This question is of interest because clinicians who are unfamiliar with the differential diagnosis of apathy (Marin, 1990) often infer that patients who show apathy are depressed. It was approached with the multitrait-multimethod matrix procedure (Campbell and Fisk, 1959), which has been used widely in construct validation (Crocker and Algina, 1986). According to the multitrait-multimethod matrix procedure, validity assessment requires measuring two or more constructs and then evaluating each construct by two or more methods to demonstrate: (a) reliability; (b) convergent validity—different methods used to measure the same construct should show strong positive intercorrelations (homotrait heteromethod correlations); (c) discriminant validity: correlations between different constructs measured by the same methods (heterotrait homomethod correlations) should be substantially less than the convergent validity coefficients. In this study, the constructs evaluated are apathy, depression, and anxiety. Each is separately evaluated by interview and by paper-and-pencil procedures.

2. Does the AES differentiate between groups according to levels of apathy? On the basis of clinical descriptions (see **Methods**), we hypothesized that subjects with probable Alzheimer's disease (AD), right hemisphere stroke (RH), and major depression (DP) would have higher mean levels of apathy than normal subjects (NL). We also hypothesized that RH subjects would have higher levels of apathy than left hemisphere stroke (LH) subjects (Robinson et al., 1984).

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AES Scoring & Administration

General Considerations:

Three versions of the AES: The foregoing definitions are incorporated into the AES. The AES is an 18 item scale. It requires 10-20 minutes to administer depending on the subject's abilities and the version used. There are 3 versions of the scale: **self-** (**AES-S**), **informant** (**AES-I**; significant other, e.g. personal or professional caregiver), and **clinician** (**AES-C**) rated versions. This affords flexibility in rating apathy since the clinical population and clinical circumstances often dictate a preference for one form of administration over another[3]. The clinician version has somewhat better validity than the informant version. The overall validity of the AES-S is less than the AES-C and AES-I. Therefore, when possible the clinician version is preferred. The AES assessment of apathy is based on subjects' current functioning. For outpatients or patients rated within 3-4 days of hospitalization the period rated is defined as the previous 4 weeks. Changes necessary for hospitalized and other institutionalized individuals are discussed later.

Types of items: Each version consists of the same 18 items. Consistent with the operational definition of apathy, there are 3 types of items: each item is primarily an index of overt goal-directed behavior, goal-related cognitions, or goal-related emotional responses. This categorization of items is indicated in the right hand column of the clinician version of the AES-C: B= behavioral item; C= cognitive item; E= emotional item[4]. Items are worded with positive or negative syntax (+ or -); most are positive. The rating of Self-evaluation (SE) and quantifiable (Q) items, as denoted in the right hand column of the AES-C, is described below.

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Two types of administration procedures: The self and informant rated versions are administered as *paper and pencil tests*. Cognitively impaired patients can provide meaningful responses[5], particularly if the rater reads the items and records the subject's responses. Experience to date (2) suggests that primary caregivers are sensitive, reliable sources of information about apathy.

The AES-C is administered as a *semi-structured interview*. Items are rated based on current functioning as evident from the subject's "thoughts, feelings, and actions" during the past 4 weeks.[6] It is crucial to understand that the AES-C ratings are based on the clinician's assessment of the patient's self-reports. In other words, except for the self-evaluation (SE) items discussed below, the *ratings given for the AES-C are based on the clinician's best judgment (or "objective" assessment) of the subject's motivational state.* To carry out this assessment, *verbal and non-verbal data must be evaluated.* Specific Instructions (below) describes how to integrate verbal and non-verbal observations. Two principles underlie the use of non-verbal information: first, as indicated in the above definitions of apathy and motivation, *emotional responsivity provides information about motivational state*; second *how the individual deals with questions (verbally and non-verbally) is assumed to provide information about how other activities are dealt with* (for example, with initiative, exuberance, or lethargy). Thus, the AES-C interview is viewed, in effect, as a "motivational laboratory": what the subject says and how it's said provides a valid sample of subject's overall motivation in other situations.

Learning to use the AES:

Basic clinical skills suffice to apply the above definitions to administering the AES. The detailed instructions that follow likely will seem complex on first exposure. With minimal experience, however, they are readily appreciated and applied. Before attempting to assimilate the detailed instructions it is recommended that a new user read the sections titled Specific instructions and the introduction section of Guidelines for Coding Severity. Then administer the scale to 1 or 2 individuals showing minimal and moderately severe levels of apathy. If unfamiliar with the syndrome of apathy (4,8), it is better to begin with neurological patients who present lack of motivation without depression; patients with Alzheimer's disease of mild to moderate severity often fulfill this requirement. After this brief experience with the AES, the utility of the additional material is readily assimilated.

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[5] Meaningful ratings can be obtained in subjects with Mini-mental state scores as low as 10, particularly if they are rated using the AES-C or AES-I.

[6] This information can be supplemented by other clinical information when the rater judges the subject's responses of doubtful validity. In practice this is rarely necessary. For clinical purposes the use of external information presumably enhances the validity of AES-C ratings. However, the impact of this procedure on AES scores has not been evaluated.

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SAMPLE

Apathy Evaluation Scale (Self-rated)

Name: ____ Date: ___/___/___

For each statement, circle the answer that best describes the subject's thoughts, feelings, and activity in the past 4 weeks.

1. I am interested in things.

   NOT AT ALL SLIGHTLY SOMEWHAT A LOT

2. I get things done during the day.

   NOT AT ALL SLIGHTLY SOMEWHAT A LOT

3. Getting things started on my own is important to me.

   NOT AT ALL SLIGHTLY SOMEWHAT A LOT

4. I am interested in having new experiences.

   NOT AT ALL SLIGHTLY SOMEWHAT A LOT

5. I am interested in learning new things

   NOT AT ALL SLIGHTLY SOMEWHAT A LOT

SAMPLE

This is the end of the SAMPLE AES- Self Rated questionnaire.
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Apathy Evaluation Scale (Informant-female)

Name: ____ Date: ___/___/___

Informant's Name: ______________________________ Relationship:___________

For each statement, circle the answer that best describes the subject's thoughts, feelings, and activity in the past 4 weeks.

1. She is interested in things.

   NOT AT ALL SLIGHTLY SOMEWHAT A LOT

2. She gets things done during the day.

   NOT AT ALL SLIGHTLY SOMEWHAT A LOT

3. Getting things started on her own is important to her.

   NOT AT ALL SLIGHTLY SOMEWHAT A LOT

4. She is interested in having new experiences.

   NOT AT ALL SLIGHTLY SOMEWHAT A LOT

5. She is interested in learning new things.

   NOT AT ALL SLIGHTLY SOMEWHAT A LOT

SAMPLE

This is the end of the SAMPLE AES- Informant Female questionnaire.
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Apathy Evaluation Scale (Informant-male)

Name: ____ Date:___/___/___

Informant's Name: ______________________________ Relationship: ____________

For each statement, circle the answer that best describes the subject's thoughts, feelings, and activity in the past 4 weeks.

1. He is interested in things.

   NOT AT ALL SLIGHTLY SOMEWHAT A LOT

2. He gets things done during the day.

   NOT AT ALL SLIGHTLY SOMEWHAT A LOT

3. Getting things started on his own is important to him.

   NOT AT ALL SLIGHTLY SOMEWHAT A LOT

4. He is interested in having new experiences.

   NOT AT ALL SLIGHTLY SOMEWHAT A LOT

5. He is interested in learning new things.

   NOT AT ALL SLIGHTLY SOMEWHAT A LOT

6. He puts little effort into anything.

   NOT AT ALL SLIGHTLY SOMEWHAT A LOT

SAMPLE

This is the end of the SAMPLE AES- Informant Male questionnaire.
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Apathy Evaluation Scale - Clinician Version [AES-C]

Name: ______________________________ Date: _____________ Rater: ______________________________

Rate each item based on an interview of the subject. The interview should begin with a description of the subject's interest, activities and daily routine. Base your ratings on both verbal and non-verbal information. Ratings should be based on the past 4 weeks. For each item ratings should be judged:

Not at All Characteristic	Slightly Characteristic	Somewhat Characteristic	A Lot Characteristic
1	1	3	4

__ 1. S/he is interested in things. + C Q
__ 2. S/he gets things done during the day. + B Q
__ 3. Getting things started on his/her own is important to her/him. + C SE
__ 4. S/he is interested in having new experiences. + C Q
__ 5. S/he is interested in learning new things. + C Q
__ 6. S/he puts little effort into anything. - B
__ 7. S/he approaches life with intensity. + E
__ 8. Seeing a job through to the end is important to her/him. + C SE
__ 9. He/she spends time doing things that interest her/him. + B

SAMPLE

**This is the end of the SAMPLE AES- Clinical questionnaire.
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